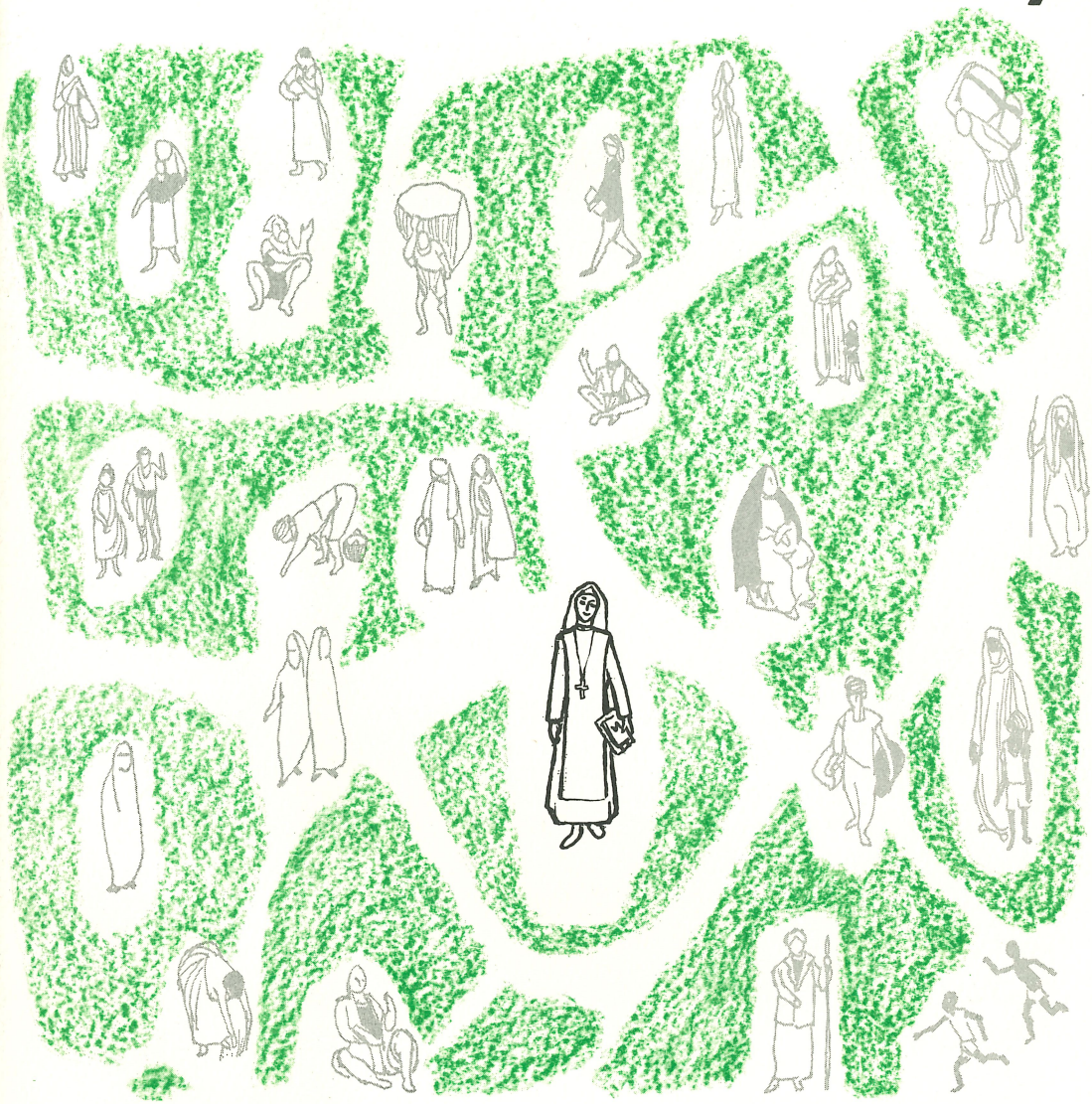
Medical Missionary



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the medical missionary

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"YOU WHO HAVE THE LIGHT WHAT ARE YOU DOING WITH IT?"

Sister M. Angelica

(Paul Claudel)

The whole world is clamoring for nurses; one half of the globe considers them indispensable; the other half eagerly awaits their help to cure their ills, and to assist them build a better world. If the United States with one nurse for every 300 persons is clamoring for more of them, consider the countries, where the proportion is still only one nurse for every 43,000 to 50,000 persons. Consider the thousands of villages without medical aid of any kind — no doctors, nurses, or trained midwives. Consider the hospitals in towns without even one nurse. They exist! Yet, how many think of these countries, these people, crying out for medical help, where millions of poor and sick lead a life of misery and pain, day after day, year after year, because there is no one to bring them relief and knowledge?

Today, the life expectancy, in Europe and the United States has reached the high peak of 68 years. The 500 million people living in South East Asia, can expect to live only 25 to 35 years. We read of epidemics there of cholera, plague, smallpox—of millions afflicted with malaria, T. B., and trachoma causing blindness, of the high infant and maternal mortality. Surely the need for nurses in these places is staggering beyond comprehension.

Most of us, hearing these tales of misery and disease, of the immense need for medical care in the underdeveloped regions of the globe, express a vague sense of thankfulness that we live in the United States, and then pass on to things more immediate, more pleasant-sounding. A nurse, however, may react in an entirely different way. She knows that many of these communicable diseases can be brought under control or eliminated by the application of public health principles, and by training health personnel who in turn can teach others. She knows that the mission fields or underdeveloped areas, are a most glorious battlefield for a nurse. There, where the needs are greatest, she knows she could use all her talents and training to fight the battle against ignorance, superstition and preventable disease. She sees in these facts and figures a great challenge to her profession and to herself.

Still very few accept the challenge . . . very few are willing to give up all . . . home, family, security, comfort etc., and dedicate all to the service of God and the relief of suffering humanity. Why? Perhaps it is because very few understand the totality of their vocation as a Christian . . . to spread the light of Christ, to become channels of His Grace and charity to all men. They do not fully comprehend their link with all others in Christ, their Christian responsibility for one another. Too often their "light" is confined, hidden under the "bushel" of their own petty personal interests, without thought for others outside. Their light is smothered; its weak flame does little good to anyone. *No man lights a candle and puts it under a bushel,* says the Gospel, and, YOU ARE THE LIGHT OF THE WORLD. How far-reaching are these words! If they would only bring forth their light, feed it with the fuel of greater, wider and more universal charity

towards their neighbor, then it would diffuse itself afar.

"Every Christian is charged with a part of humanity to conquer, which he has to cause to make its way to God, and every Christian is one with all other Christians and ultimately with all other men, and with the world in its total history." (Lochet). Which part has God destined you, the nurse, to conquer? Surely the sick and suffering are your special charge, especially those most in need, and far off.

* * *

This issue of the Medical Missionary is dedicated to all nurses and to the mission Sister-nurse especially. Like Our Lady in the mystery of the Visitation, hearing of her cousin's (her neighbor's) need she has sacrificed her personal comforts and accomplishments to serve others. Like Mary she goes joyfully, because it is love that impels her. Through her profession and dedication she becomes a forerunner of the Gospel of Joy into homes and hearts where others may not enter. For her the mission fields are not only a challenge but an opportunity to represent and bring Christ to the suffering — showing forth His mercy, His kindness, His love to all without distinction of race, creed or color, making them realize that all men are brothers, children of the same Heavenly Father. Her charity brings them the best modern medical care possible, for charity gives the best — and almost immediately she begins to train local young women as nurses, midwives, etc., to extend the work and help raise the standards of health in the country. These people become her people. She studies their language, their culture; sympathizes with their ideals and aspirations. Her influence is far-reaching. More and more she finds spread out before her unlooked for horizons of spiritual, moral and physical good — a new world in the making. She has placed her light on a candlestick that it may give light "to all in the house", that all may feel the radiance of Christ's Charity.

Millions are waiting for this light — the light of Faith, and hope, and healing. YOU WHO HAVE THE LIGHT, WHAT ARE YOU DOING WITH IT?

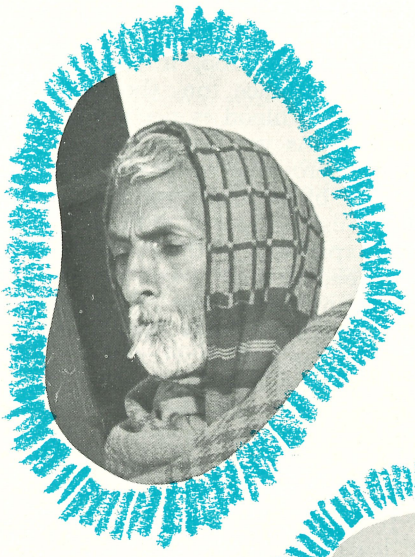
Over the hillside country, Mary went
Carrying Christ; and all along the road
The Christ she carried generously bestowed
His grace on all she met. She had not meant
To tell she carried Christ. She was content
To hide His love for her
But all about her glowed such joy that into
Stony hearts love flowed
And even to the unborn John
Christ's grace was sent.
Christ in His Sacrament of love each day
Dwells in my soul a little space and then
I walk life's crowded highway, passing men
Who seldom think of God. To these, I pray
That I may carry Christ, for it may be
Some would not know Him but through me.

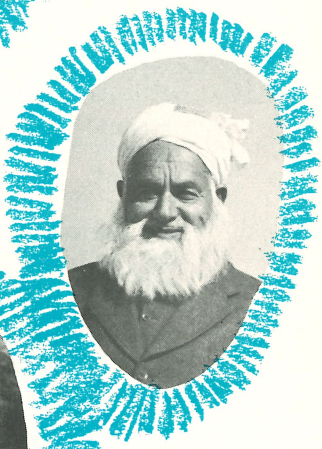
—Anon.

A MISSION SISTER-NURSE IS LIKE THIS . . .

Sister M. Gabriel, B.S.R.N., R.M.

Sr. M. Gabriel, R.N., the author, a native of New Jersey, is now in Rawalpindi, West Pakistan.





No doubt, if you are a nurse or are familiar with hospital work, you must often wonder just what a Sister-nurse's job is like in the missions. Well, on the whole it is pretty much the same as it would be back in any hospital at home . . . with a few differences. There is the perennial problem of shortage of nurses, busy days, difficult patients, etc. Most likely the Sister-Nurse will be in charge of one or two wards or a whole department. Her work will be primarily supervision and education of local student nurses, since the greater part of nursing care is given by the students. One or two trusted staff nurses in a department is the best one can hope for.

In a country like Pakistan where the women are so restricted and so few are educated, a Sister's time is spent talking to the patients about their condition and treatment and probably even more time talking to the relatives. The few doctors with their mounds of work cannot spare the time it takes to explain matters to enquiring parents

and anxious relatives. This generally falls to the Sister on the wards. Permission must be expressly obtained for each operation . . . there is no blanket permission. This means a lengthy explanation of the patient's condition, reason for operating, treatments necessary, etc. Also, and not the least important, allaying fears for the safety and recovery of a dear wife, husband or parent. Then too, it is almost a daily occurence on the women's wards that blood is needed for the patient. As yet the public has not been thoroughly educated to the idea of blood transfusions, so each pint must be gotten with difficulty . . . explaining to the relatives why it is needed, that it won't cause the donor any harm, that injections are not sufficient, that we have no blood to sell, that it can't be purchased in the bazaar, etc. After this, the somewhat reluctant donor has to be taken personally to the laboratory, led by the hand, lest he get away or change his mind.

It is no exaggeration to say that at least an hour and a half a day is spent by the ward Sister in this fashion talking to relatives of the patient. It is a marvelous opportunity of nursing the whole patient, the patient as a member of a family, with a husband and children and relatives who are very much concerned. It is a good opportunity for educating the public in health matters . . . giving them simple advice on diet, cleanliness, etc. After one lengthy explanation to the relative of a patient with a kidney condition he said, "You mean to say she has *two* kidneys?" . . .thus a simple little lesson in anatomy was given.

For the Sister in the Maternity and pediatrics departments, there is great scope for teaching mothers the secret of feeding their babies properly. One day in the out-patient department, I tried to convince the mother of a scrawny nine month old baby that she should feed him other foods besides milk, but I could tell by the look in her eye it was a losing battle . . . never had she heard of such a thing! How could the baby digest food! No one in her family had ever done it, etc., when suddenly I got the inspiration to take her up to the pediatrics department . . . it was just feeding time. All I needed was to show her some of the babies even younger than hers eating eggs, mashed vegetables, minced meat, etc., liking it and getting fat. One such demonstration is worth a thousand words . . . she went home convinced.

Many such opportunities occur in all departments of the hospital. Some of this may sound very simple and easy but remember that much of it has to be done in Urdu, often necessitating an interpreter if the Sister's knowledge of the language is still limited. Only the other day I was trying to explain to an enquiring husband that his wife was getting special treatment for worms. He started to laugh. Later the nurses told me I was saying that she was being treated for ants . . . the words being very similar to Urdu. When we get pa-

The Sister nurse must show forth Christ's compassion for the sick

tients from out-stations who don't even speak Urdu, the only solution is to resort to sign language.

As to the actual nursing of patients we find that they are the same the world over . . . the same eccentric old *babas* (men) who so exasparate yet charm us, the dear old *ammas* (grandmothers) who hold one's hand and look for comfort, the frightened but grateful young women, the more sophisticated young men, the mischievous children and the affectionate babies. On the whole patients who come for admission are a good deal sicker than those at home, as their general condition is often poor to begin with. We now think a woman who has reached 9 grams of hemoglobin (60%) a rather *good* surgical risk. Many have tried all kinds of home remedies and waited, hoping for the best before coming in, which only complicates matters for us.

So you see the Sister-nurse has to be supervisor, instructor, public relations officer, health teacher, mother and general handy-man. The Sister-nurse may be up to her ears in work, annoyed with worrisome relatives, perplexed by the shortage of nurses, supplies and equipment, tried by the newest probies, but never — we can promise you . . . is she ever bored or does she find the work monotonous. It is surely a satisfying task which brings out all that is in a good nurse and a good religious. She can show to those who are not Christians that she is sincerely interested in the patient as a person with a body and soul. She may not be able to make converts but she can make the sick feel that she represents Christ's charity and kindness. Results may not be visible but barriers of prejudice and intolerance slowly melt away. In this also, one kindly gesture is better than a thousand words.

The Sister-nurse's only complaint is that unfortunately she is not twins and cannot bilocate. Demands on her time and service often make that a fervent wish. At the end of a particularly hectic day, she can't help praying that maybe one more Sister-nurse at home could be spared or maybe some young nurse might receive the light and grace to follow her vocation and add to the number of Sister-nurses in the missions. The generosity and self-sacrifice it demands will not go unrewarded even in this world . . . of this I can assure you! And in the next there will be the joy of hearing those words: "As long as you did it to one of these my least brethren, you did it unto Me."

20 Years a Nurse and a Midwife in India

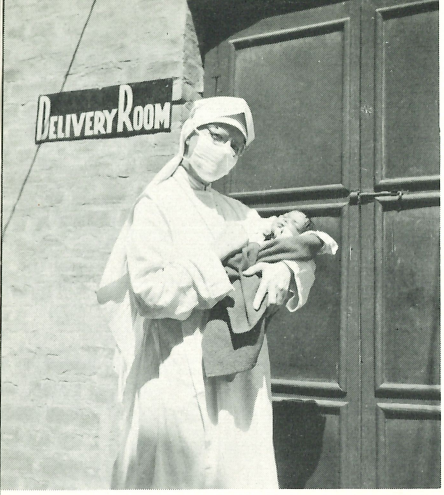
Sister M. Stephanie, R.N., R.M.

The day of my arrival in India, is still vivid in my mind. It was January 16, 1936 when I first set foot on the land of my adoption. As the ship was coming into harbor, I stood on deck watching. Several times, one or two of the passengers said to me, "Sister, be careful, don't stand in the sun," and I said, "thank you," stepped back, only to find myself back at the railing, for I did not want to miss anything. That night I had a high temperature, but a little aspirin and a good sleep was all I needed.

After a few days the train brought us across country, up to the north of India to Rawalpindi, which is now Pakistan. Yes, I was assigned to Holy Family Hospital, at the time our only hospital in India. The hospital was small; the number of patients ranged from 25 to 50 if I remember correctly. The first morning

I made rounds with the doctor and Sister M. Laetitia, who was then superior of the hospital. Entering a small private room I was introduced to Mary, one of the student nurses. She was in bed with a cold and sore throat. As we came in, a little chicken left by the verandah door, cackling away, and Mary handed us the egg the hen had laid on her bed. Yes, chickens had free entry to the hospital in those days. Now, in the new hospital things have changed, but then you would sometimes find one tied to the patient's bed, awaiting its doom—the patient's next meal. The hospital was for women and children, there were no male patients. The days of sulfanilimides, penicillin, and other antibiotics had not yet come; they were still unknown discoveries. Septicimia and puerpural sepsis were common. How could it be otherwise as the mothers had their babies at home with no attendant, or if they had one, it was an illiterate woman of the lowest caste? The patients used to have to stay in the hospital for months and required a great deal of nursing care.

Operations were not scheduled for an exact time in those early days. I used to be fascinated as I listened to Sister Margaret Mary, R.N. trying to explain to a husband, mother, or



Sr. M. Stephanie, R.N. (the author) with a new born, Holy Family Hospital, Patna, India

father why the patient needed an operation. She even used drawings to convince them. Then, when the consent was given the whole hospital machinery went into action at once, before the patient or relatives had a chance to change their minds. Two hours later the patient would be on the operating room table.

Then there is the case of Bibi Jan. Bibi Jan came to the hospital to have her baby. The doctor's verdict was prepare for a caesarean operation. The male members of the family got together. The answer was "No." Poor woman what would happen to her? In the meantime Bibi Jan was taken home. We kept praying that the men would change their minds once the pains became severe. A week later, on a Sunday morning, in came Bibi Jan. "Do whatever you think best," she said. And when a beautiful boy was born by caesarean section, how happy everybody was!

If a patient died in the hospital in those days, (and looking back, I think it was marvelous that so many got better without antibiotics) we would get a holiday or two, for on morning rounds you would be greeted with "Nam Katna," meaning "cut my name off the register, I am going home." So most of the time, when death seemed imminent and there was humanly speaking nothing we could do for the patient, and the relatives would ask to take the patient home to die, we gladly gave our consent. Most people in the East prefer to die at home where they can follow out their own customs in private.

After having been a member of the hospital staff for almost two years, I was asked to take charge of the Maternity and Child Welfare Centre in the city itself. This meant teaching the native midwives *Dais,* who were illiterate, and also supervising their work in the homes. It called for much patience, as they did not see the need for scientific and hygienic training. The mother-in-law might say, "Well, I have had 12 or more children myself, and I am still alive and nothing ever happened." Slowly, however, g r o u n d was gained, and the people acquired confidence in the hospital, and in the hospital Sisters. After all, I represented H o l y Family Hospital to them. In the course of time I was admitted to many homes, rich and poor, and of different castes and standards. The arrangement w a s that the *Dai* would call me for the confinement to supervise her work, to teach her how to do a good job in the home with the things available, etc. After one or two years of training, these women were given an oral and practical examination, and then they would be registered and be given a proper certificate. These certified *Dais* were to replace all the old ladies who had given their services for years without any real knowledge except what they had seen their mother do. The work had been handed down from mother to daughter all through the ages.

In a certain caste, when a baby boy is born, the little boy has to enter this world of ours through a

Muslim woman, with burkha thrown back. Holy Family Hospital, Rawalpindi, W. Pakistan

hole. So immediately after the birth, the *dai* is given a large round brass plate and an ax-like instrument. With this she has to cut the plate in such a way that a round rim remains and the baby is handed to the mother through this hole. On one occasion, unfortunately the plate broke in two. What to do? For a moment there was a dreadful silence in the room, then the face of granny lit up with a smile. There was another room adjoining the sick-room and there was a window between them. So the baby entered this world through the window, and re-entered the patient's room through the door, and everybody was happy and congratulated granny for saving the situation.

Jaiflan was my star pupil. She only passed at the second attempt, but she learned her lessons well, especially the most important one of cleanliness. After every case, she would take a complete bath, wash her hair, and put on clean clothes. The examiner tricked her the first time she appeared. She was told to scrub her hands for the delivery, and after she had finished doing so, the examiner handed her a towel, and she said "thank you" and took it to dry her hands! Today after twenty years she is still on the job, and is still seen at the Holy Family Hospital in Rawalpindi, bringing in her patients for a checkup, or if they need hospital care, etc.

After several years of work on the district I again joined the staff of the Holy Family Hospital and took my part in the teaching of the midwives and supervision of the night work. During those years people came to know about the Holy Family Hospital, and the number of hospital deliveries rose to nearly 1,000. In the hospital they could not observe all their customs, but one night I had to help a little boy enter into this world through a hole. The minute the baby was born, Grandma got excited and tried to get near the student whose case I was supervising. Having worked on the district, I soon realized what was wrong. Grandma had torn a hole into one of the patient's garments, and was trying to get the baby handed to her through it. Of course the student was worried about keeping sterile, as the old lady was getting close to her, so I said, "let me have the baby," and gave it to grandma right through the hole she had made.

Another night the maternity ward was full, not an empty bed, as usual. We had just delivered a bouncing baby boy, and as I was getting ready for the next case I told the nurses to please move the patient back to her own bed in C-6. Soon they came back to tell me that the bed was occupied. But no, that couldn't be, I had brought the patient to the O.R. myself and there had been no other admission. Soon the mystery was solved. The old mother knew that her patient was in good hands. She had perfect confidence in the Sisters and in the hospital. So, when sleep overcame her she just got into the patient's bed and was very much surprised to hear that all was over.

Home visiting in Thuruthipuram, South India

After 11 years on the Staff of Holy Family Hospital, Rawalpindi, I was called to Patna, India, to take charge of the hospital there in the Old Cathedral compound. Our patients were mainly Hindus with a few Moslems and some Christians. A few temporary buildings had been put up during the war, with a tiled roof. The number of inpatients in 1947 was around 100, with a steady increase. Here I met my first cholera patients. They came in, pulseless, collapsed, and I was sure they would all die. But the little nurses kept telling me, "No, Sister, they will be all right," and most of them got well. Yes, they did.

Monsoon time, and the roofs of those temporary buildings were leaking badly. What to do? In the morning you would find the patients sitting under an umbrella on the double folded mattress. We soon managed to get a permanent roof on those temporary buildings but until this was done we just told the patients, "bring your umbrella along, you might need it."

One day I was in the chapel, it was mid-day and almost time for lunch. In walked Rampiyarie with her baby in her arms. The baby had been very ill with dysentery, and for days it was just a question of life and death. Now, before going home she came to say "thank you to the Lord." She walked up to the altar-step, put her baby down on it, bowed reverently three times, and then took her baby again into her arms leaving the hospital a happy mother indeed.

Wherever we have hospitals we soon have a nurses' training school. On the whole, the Indian girls make good nurses, especially good bedside nurses. It is hard at times for them to understand a PRN order, when necessary. At evening rounds going through the maternity ward, I found a student calling and shaking a new mother, whose baby was born just a few hours before. "What is the

matter, nurse, why wake her up?" "To give her aspirin and bromides which are ordered PRN, the former for pain, the latter for sleep." "But she is asleep? Ah yes!"

After six years in charge of the Holy Family Hospital in Patna, I was asked to go to the South of India to start the Archbishop Attipetty Jubilee Memorial Hospital, located in a little village on the west coast of Malabar. The village is in the back waters, and the only approach is by the vanchi (small country boat) which takes you across the canal to the village.

This is the people's first experience with hospitals, and hospital Sisters, and they are very docile. The majority of the people are poor, and have never left the peninsula. In a hospital like this everything is put to use, and you have to be "Jack of all trades." We make our own I.V. solutions, we prepare the tubing; it's all worked out to the last detail, how it has to be done. It's a great deal of work—yes, but we have no reactions, and our poor people have I.V. glucose, saline, dextrose, and even blood transfusions, when they need it.

We have what we call a preliminary training school. We had to find some hands to do the routine work, and thus it started. Our training schools in the north give their courses in English; the girls down here do not know sufficient English, thus they come here for a year to the Archbishop Attipetty Jubilee Memorial Hospital. They help with routine work then go on up north for their degree.

Dear old Mariyam, just came to me, medicine in hand, saying "*cash illa*" (no money). Well, I said to her, go and say a prayer that the Lord will send us more benefactors . . . Sister M. Th. Pauline wonders what is going on in the chapel? Who is talking so loudly? It's only Mariyam carrying out orders.

I have many other stories I could tell; they would fill a book. I leave it to the reader to ask questions, and I will try to answer them all. It is very different to be a nurse and midwife here, but it is wonderful . . . who will come and join me?

R.I.P. *Please pray for our benefactors recently deceased:*

His Eminence, Samuel Cardinal Stritch
Rome, Italy
Most Rev. Bishop Bonaventure, O.C.D.,
Kottayam, India
Most Rev. Peter L. Ireton, D.D.,
Richmond, Virginia
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Mrs. John Walczak
Ellwood City, Pa.
Mr. John Ward
Los Altos, Calif.
Mrs. Anna Walsh
Brooklyn, N.Y.

Sister M. Bonaventure, B.S.N.Ed.

NURSING IN EAST PAKISTAN

Student Pankajini and Sr. M. Juliana, R.N.

Sr. M. Michaela, R.N. capping Agnes.

This coming August 14th will mark the eleventh anniversary of the birthday of a new nation—Pakistan. On August 14th, 1947, Great Britain granted to Pakistan those contiguous areas from her old Indian Empire which showed a majority of Muslims by population. This new nation is divided into two parts—East and West Pakistan—separated by a thousand miles of Indian territory.

East Pakistan, which, prior to partition, was the eastern half of the Province of Bengal, is a semi-tropical area situated at the head of the Bay of Bengal and almost surrounded by India, although it touches Burma in the southeast. After partition, East Pakistan, with its population of 45,000,000 found itself virtually without developed services and in the position of having to build up almost from the ground, with little money to do so. The chief obstacle to progress was lack of trained personnel. Institutions for training of medical and pre-medical personnel were practically non-existent in the new East Pakistan. Added to this, environmental conditions were very unfavorable. Situated at about one foot above sea level, a great part of the Province is under water for part of each year, making communications difficult. Fly and water bourne diseases are the chief threats to life. Malaria, malnutrition, helminthiasis, anemia, primitive conditions associated with child birth, low resistance to infection, are also prevalent.

It was against this background that plans for the construction of Holy Family Hospital, Dacca, were begun. The cornerstone was laid in 1953, The work on the hospital continued until the much-awaited day, March 25, 1956, when the hospital was officially opened by the Honorable Fazul Huque, Governor

of Bengal, in the presence of many friends.

The whole problem of training nurses was, and continues to be an urgent one. During the ten years from 1948 to 1957 only 75 students (these are official published figures) completed their course in general nursing and midwifery. Seventy-five nurses for a population of 45,000,000!

Even though the new Holy Family Hospital was not yet completed, it was decided to admit the first class of students on October 15th, 1955 so their preliminary training could be begun. From all over the Province they came, from Chittagong, from Kusthia from Barisal, from Krishnagar, all with different backgrounds, but all with one aim—to become a nurse . . . .

PRESENTING TWO OF OUR STUDENTS . . .

Meet Agnes

Born in Akyab, Burma, of a Buddhist mother, Agnes was educated by The Notre Dame de Mission Sisters in Chittagong, the "port" city of East Pakistan. When Mother Benedict, M.D., arrived in Dacca, with Sister M. Bernard to begin work on the New Holy Family Hospital, Sr. M. Bernard became seriously ill and it was Agnes who helped care for her. Inspired with the idea of becoming a nurse, Agnes returned to Chittagong to complete her education. At last her dreams came true. She joined the first class of students arriving on October 15th, and her nursing education began. It was a memorable day for all. Classes were held in one of the finished wards, while two other wards served as dormitories for the future nurses.

Educated in an English school, Agnes had no problem with classes. She learned easily and enjoyed her studies. With the first students she threw herself right into the work of getting the hospital ready for opening. By March 25th, 1956 (the special opening day) patients were arriving one after the other. The students had a difficult time; it was a brand new modern hospital, unlike anything they had seen before, coupled with the fact that there were no "older" students to help (or hinder) them. They had no precedents, but they were a willing group and worked hard during those early days.

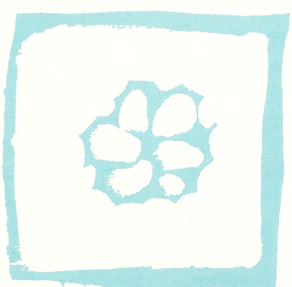
By December of 1956, Agnes was ready to sit for her Preliminary First Year examination, which she passed successfully. The time since then has been packed with further studies and activities. Agnes spent extra time in our operation theatre, and has become one of our best "scrub" nurses. By next December Agnes will be ready for her Final Examinations in nursing. Please remember her in your prayers.

Meet Pankajini . . .

A daughter of East Bengal, Pankajini (meaning water lily) was born in Barisal, two days' journey from Dacca. We still remember Pankajini when she arrived, tired and sick from the trip. But after a few hours rest she was alert and energetic again. Although she had passed the matriculation examination (just as Agnes had) English was not her mother tongue and she had considerable difficulty with classes. Still she had perseverance and, more than most of the girls, the vision of what good nursing care would mean to her people. She had seen her people dying of cholera, small-pox, typhoid, dysentery, malaria, and other diseases, many of which have been eradicated completely in other parts of the world. Pankajini struggled

during her early period of training. She had many setbacks. *Every* beginning is difficult. Because of her indominitable persistance and unquenchable enthusiasm, Pakajini will also be ready for her Final Examinations in December. After taking one year more of midwifery (which is required here, since all normal deliveries are done by midwives) she will go back to her native town to bring skilled nursing care to the sick who are now cared for in a hospital which has not *one* trained nurse on its staff, not even a matron.

These are two of Holy Family Hospital's first nurses. Please pray for them and for those who will follow them. The quality of any profession depends upon the individual qualities of its members. Pakistan needs nurses desperately, good nurses, and these students we are training today are destined to be the leaders in this profession which in Pakistan is still in its very infancy. Today in East Pakistan the Trained Nurses Association has only 51 members. May our future nurses swell the ranks to hundreds more in years to come.



LEAGUE OF GRATITUDE

Three-fold Purpose: *to thank God for the priceless gift of FAITH; to help bring that gift to those in mission lands; to share in all the works, prayers and sacrifices of the Medical Mission Sisters throughout the world.*

Dear Sisters:

I want to become a member of your LEAGUE OF GRATITUDE. As long as I can I will send one dollar or more a month. Please send me a monthly reminder.*

Name _____

Street _____

City _____ *Zone* _____ *State* _____

(**May be changed or discontinued at any time.*)

NURSING IN INDIA IS *DIFFERENT*

Sister M. Carol, R.N.

Sr. M. Carol, R.N., (Hammond, Ind.) the author, in India.

Someone has offered to write a text-book on nursing in India in three months! They might get the trolleys and trays set up correctly and add the favorite "curd retention enema," specific for cholemia patients, to the litany of enemas, but I am sure they would never get down to many of the fine points of nursing here.

Take electricity for instance, perhaps you think it has nothing to do with nursing—but if you were in the middle of a major operation and the lights went out you would soon see that it is very pertinent. The nurses really have to be on their toes to remedy the situation. Our O.R. staff has it down pat: one runs to the fuse-box, one arms herself with all the flashlights, and a third gets the truck to shine its headlights in the window so the circulator can see if the blood is going, and the patient living or dead. Before we had this crisis systemized we had some near calamities. Take the day, Sister Leonie just got the forceps on the baby's head and presto, no lights. A well meaning junior nurse came sauntering in with a candle, and the patient getting open drop ether! She had barely retired with the lasting impression that candles and ether do not go together, when another helpful appeared on the scene with the old stand-by kerosene lantern! So you see why O.R. equipment in India must include powerful flashlights, and warnings to exclude all candles and kerosene lanterns.

No one outside of India would consider water a problem. Here, however it poses a big problem: before the monsoon by its absence, and during monsoon by its super abundance. Let's look at the pre-monsoon period first. Usually the city supply will be cut off from one to four o'clock every afternoon, so the ingenious nurse will fill all available containers before one o'clock so she will not be caught with her hands all soaped up and not a drop of water to rinse with. Two nurses are assigned day and night to the water brigade. Their duty is simple, but life saving. They go from bed to bed making the patients drink water, as the belief here is that all food and drink should be stopped at the first sign of illness. Merely telling them

to drink water makes no impression, you must also pour it down their throat.

Which brings up another point. Giving medicines here is entirely different. The patient lies flat in bed, opens his mouth enough to drop in a baseball and you empty all the pills in at once, then pour in a big mouthful of water and in one masterful gulp all goes down, I forgot to mention the preliminary step in giving medicines: calling the patient's name. Here, in India, names do not mean so much. A patient will be Shanti on Tuesday and when she returns on Friday will swear her name is Radha. Some days are inauspicious, so to hide their whereabouts from the gods, they will deliberately change their names. The many blank looks, as you call names from your medicine tickets, assures you that it is another "incognito." Nurses in India must not rely on names but must be entirely familiar with all the patients, especially when the hospital becomes crowded. Just imagine for a moment having mattresses with patients on emergency cots, babies in orange crates, plus patients sitting under the trees, waiting for their family to take them home, or waiting for admission to another improvised bed. Giving medicines under these conditions is nothing short of hilarious. Imagine reading "M-ward extra 1, 2," etc., "baby in box under M 6", "patient under tree," on your medicine ticket!

Sr. M. Aquinas, R.N. (Bronx, N.Y.) sets up an I.V. Patna, India.

Then comes the monsoon. Water turns the compound into a lake, so running back and forth to Central Supply Room is indeed a problem. We forget professional decorum as nurses take off caps and shoes and envelop themselves in a plastic tablecloth to sprint across the ward for some tray, hot water or syringe.

The rains bring cholera which our nurses can diagnose at a glance. They go into action immediately whenever the patient arrives in the office, waiting room, or still in the doolie in which they were carried from the village, as immediate intravenous saline may be the difference between life and death. Sometimes unbelievably large quantities of fluid are necessary before the patient improves. One night a cholera patient came in, in a very serious condition. Sister Leonie, M.D., had to get up many times to re-start the I.V., as the patient was very restless and the needle came out frequently. Finally she just stayed up and held the needle herself. Sister Aquinas relieved her for Mass. About 11 A.M. the patient had received 20 pints of

intravenous fluids and was on the road to recovery. She was sleeping quietly when her husband walked in, clad in dhoti and bare feet and with the air of the chief of staff approached the bedside, felt the patient's pulse, turned and said to the nurse: "Bach gya" (she is saved) and home he went to inform everyone that she would live.

Next, we could take up the problem of fevers. When the temperature of the room is 105°F, and the temperature of the patient between 102° and 108° it becomes a major procedure to teach probies to take temperatures correctly. I have never seen in any text-book a warning for the poor unsuspecting nurse to remove the thermometer quickly when it reaches 107°, or she will find herself staring dumbly as the mercury shoots out of the top, and she is left with an empty tube which she must replace at her own expense. This punishment hastens the time of learning tremendously! Then consider the problem of immediately getting it into the patient's mouth so it will record *his* temperature and not that of the room.

While we are still on fevers, I could bring in the different methods of getting the fever down to a nice respectable 103°. In the U.S.A. you would probably give an aspirin, plus the specific drug for the particular disease; but here in India, aspirin takes too much out of a patient, and as many have TB also, it is rarely used. (It is used only in cases such as malaria when the temperature will stay down; in typhoid, Kala-Azar, and TB, aspirin only brings the fever down temporarily, to the detriment of the patient.)

Our nurses become experts at "floating babies." The first time I read on the doctor's order sheet "float p.r.n.", I was heading for the Ganges when someone grabbed me and showed me the tin bathtub full of cold water in which to float little junior. It works quite well and you can actually see convulsions stop and the baby relax as his temperature drops. The cold pack is greatly in vogue for the adult who is too big to float, and our youngest probie before she has learned how to speak a complete sentence in English, has learned how to pack a patient.

I have long since forgotten what a chipped ice machine looks like, as we cannot even boast of a refrigerator that can make ice cubes! Where ice is indicated you send the "sathi" (relative) out to the bazaar and she returns in ten minutes with a chunk of ice tied in the corner of her sari, the top covered with saw dust to keep it from melting before she reaches you! Leaving it in the sari you give it a whack on the floor, as competent as any ice chipping machine, and then put a few hunks into water for a compress on the forehead, and the rest you tie into a plastic bag (rubber icebags degenerate so rapidly in the heat of India) and a better icebag I have yet to see.

You will get nowhere in India with a brisk business-like approach. It takes endless patience and repetition not only to the patient, but to all the family, and sometimes the whole village, before you win their confidence. Taking blood for laboratory work is particularly difficult as the sight of a drop of blood sends them into a frenzy. One dear soul

stood upright on the bed and refused to come down for a Kahn test in spite of a whole crew of doctors, lab. technicians, and nurses below trying to cajole her into it. We retired until her *admi* (husband) appeared at visiting hours. It was amazing to see her complete obedience to him. One word and she lay down, put her arm out and never said "boo" as we drew the blood.

Another solicitous mother not wishing to subject her darling boy to a finger prick, kissed our feet and begged us to take *her* blood and not his. I am sure she does not understand why a WBC and KA test have to be done on his blood for any benefit to be obtained.

Training nurses in India also brings up special problems. For example: no one ever wears gloves. So teaching the nurses to put on rubber gloves in the operating room is nothing short of heroic. They practice for days with unsterile ones and then dawns the big day when they are all scrubbing up to help the doctor. One young one ripped two pairs and all could see that she never was going to succeed in putting the gloves on. So while all hands were waiting and progress stood at a stand still, Sister Bertrand finally got her junior nurse gloved with forceps.

Nursing children in India is the most pleasant and gratifying of all. One boy, Lal Babu was six years old and had had abdominal pain off and on for two years, now more severe. The doctor diagnosed TB abdomen with obstruction. He never shed a tear as I carried him to the O. R. He even said the ether smelled good! Doctor found TB abdomen with ulcers, causing chronic intussusception necessitating resection. When he came around he found blood going in one tube and a gastric suction tube in his nose, but did he complain? Never a whimper. All we did was explain why these treatments were necessary and he accepted it like an old grandpa. The only thing he minded was not eating. His first food was simply devoured and after a week you would never have known that he was ever sick. His spindly legs and arms began to fill out and when he was ready to go home all the nurses hated to see him go.

Summing up some of these "fine points" you can see that nursing in India is indeed quite different. Still I would not trade our little mission hospital for the most modern and well equipped one in the U. S. A.! If you have once known the trust and confidence of these villagers, seen the begging eyes of a young mother unable to deliver her child, nursed a Lal Babu from the portal of death to the best of health, or sympathized with a young mother dying of small-pox with her brood of youngsters around her, closed the eyes in death of burn cases so severe as to give a premonition of the fires of hell, or helped bring about the metamorphosis of simple barefoot girls into professionally well-trained-nurses, you would understand why we ourselves have become true Indians, loving the land, her people and her customs through nursing and relieving in some small measuse the endless miseries which afflict mankind.

MEDICAL MISSION WORLD

Sister M. Janice

INTERNATIONAL CONGRESS TO MEET

The Seventh International Congress of Leprology will meet this year in New Delhi, India. The Congress which convenes only once every five years, will meet November 10-16. This year's Congress will discuss: Classification, Therapy, Epidemiology, Immunology, Bacteriology, Pathology and Social Aspects of Hansen's Disease.

"The Star" Jan.-Feb. 1958
Carville, La.

TROPICAL MEDICINE

Health hazards in the tropics have always been disease of parasitic origin, infectious diseases and nutritional deficiencies. Recent years have revealed that these health problems are not confined to tropical countries, but are of global concern as well. Through the efforts of International Health agencies much is being accomplished to improve the health, social conditions and economics of the tropics and thereby eradicate many of the diseases which threaten mankind.

Tropical Medicine & Hygiene
Feb. 1958

SISTER HILARY ROSS RECIPIENT OF DAMIEN-DUTTON AWARD

Sister Hilary Ross, a Daughter of Charity of St. Vincent de Paul, was recently given public acclaim for her service to patients suffering with Hansen's Disease. The Damien-Dutton Society, New Brunswick, N. J. chose Sister Hilary to be the sixth recipient of the Damien-Dutton Award. The award was given in recognition of Sister Hilary's devoted and scientific services to the patients at the U. S. Leprosarium in Carville, La., where she has been stationed for the past 36 years.

NCWC News Service

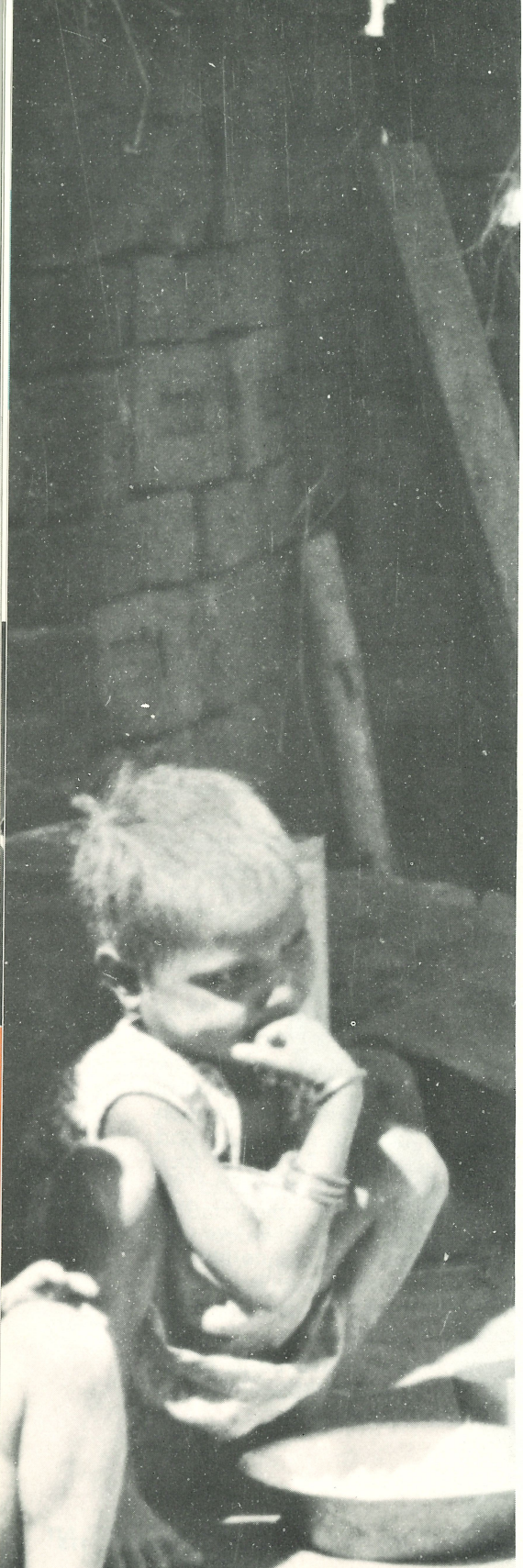
MEDICAL AID FOR EAST PAKISTAN

In April, a serious epidemic of smallpox broke out in East Pakistan. The government of Pakistan sent out a request for vaccine to a number of countries throughout the world, and a very substantial response followed. By the end of May, over 10,000 doses of vaccine had been sent to Dacca, the capital city of East Pakistan, and was being distributed to sub-divisional headquarters. During the first weeks of the epidemic up until May 10, the incidence of deaths had already totalled 14,000.

The United States responded to East Pakistan's plea for help by sending a team of nine doctors from the Public Health Service to cooperate with the officials in conducting a mass vaccination campaign.

The U. S. also sent some supplies for fighting a cholera epidemic which had started in the southern districts of East Pakistan. While there was a good indication that the smallpox epidemic had reached its peak in May, the incidence of cholera deaths had increased during that time, and it was feared it might develop into a more serious situation within a short time. Widespread epidemics of cholera have occurred in Calcutta and Bangkok also.

Alexander D. Langmuir, M. D.
Chief, Epidemiology, P. H. S.
Atlanta, Georgia



PUBLIC HEALTH NURSING IN INDIA

Sister M. Clare, M.S., H.A.

There couldn't possibly be a more fertile field in which to work just now in India than Public Health in the villages. Opportunities? Their name is legion!

Aside from the fact that Public Health always was a fascinating work because of its vast potential in getting right down to the people, there are plenty of reasons why Public Health Nursing has now become a MUST in every medical work in India.

As all know, the majority of the people (at least 85%) live in rural areas. And conversely, the majority of medical facilities are located in big cities only. This leaves literally millions — not only without medical care, but also without a hygienic environment which would include running water, sanitary facilities, electricity, etc.

The Government itself realized this ten years ago when it set up its First Five-Year Plan and was even more convinced of it when she set up the Second Plan! Some of the desired goals have had to be abandoned because of financial difficulties but the convictions are still there and the general plan is geared to reach this objective.

Our part in cooperating with the Plan is a very small but nevertheless satisfying one. Holy Family Hospital, New Delhi, is particularly well placed for work in the rural area, situated on the outskirts of the city and completely surrounded by wheatfields and villages, except for the Water Works on one side!

Holy Family Hospital is an educational institution with a School of Nursing. The hospital has tried to integrate Public Health into the basic curriculum according to the recommendations of the Indian Nursing Council. Aside from including the subject in the various courses as they are presented, it involves giving the students field work in Public Health early in their training, and steadily throughout the three or four years that follow.

Some of their experiences are truly unique and not wholly according to the text book, because before formal visits can actually take place, the people must gradually be prepared to receive the message of health. So — on a nice sunny afternoon (it's always sunny in Delhi, except during a short monsoon!) one sister and one or two students set off for the village. Julana is literally just across Okhla Road so they reach there in five minutes. Although the hospital is within a stone's throw of this village, 98% of its people have not availed themselves of its services. Why? Well, first of all because they think a hospital is a place to die! To think of it in terms of prevention of disease has never occurred to most of them. Secondly, many of the men and almost all of the women are illiterate and therefore are not able to understand when they are in need of medical care.

However, this simply high-lights all the more forcibly the great need for Public Health Nurses to work among the people. Undesirable attitudes can gradually be broken down and desirable appreciations built up by a daily meeting with these, our neighbors, in their own environment, at their own level, and at *their* convenience.

Having reached the village, the Sisters begin their round of visits. In no time a crowd of children begin to trail after them and shortly, one friendly mother appears at her door! A return smile grants entré and soon, the nurses are actively engaged in questions as to the health of the children, their diet, their grannies, their crops and last-

ly (but not leastly), Mother herself, who is 'expecting' soon. Naturally, none of these mothers will have had any pre-natal care. Those readers who might be Public Health Nurses will perhaps be reading into the next line that "mother promptly sat down to have blood pressure taken etc., etc." This *might* happen in an occasional case but the more common reply is a complete refusal to have anything to do with such goings on! One good lady told Sister that a long time ago her neighbor had allowed that thing (B. P.) to be put on her arm, and the arm went blue and she couldn't move it for days afterwards!!!

With that story, the accompanying group of neighbours with faces half-veiled, who had gathered to watch what was going on, cleared out in double quick time lest they become involved in such a disastrous procedure! To disprove such a story, one of the Sisters promptly sat down and let them take her B. P. and demonstrated at the conclusion that all five fingers and arm were functioning just as well after as before! Just such demonstrations are repeated frequently. At this point, sometimes they give in, often they don't.

Not long ago, one of these "adamant" ladies called the Public Health Nurse for her delivery and when she arrived on the scene, she found her, the perfect text-book picture of eclampsia. After a long debate in which all the relatives and many of the village elders were involved, they finally allowed her to be brought to the hospital and eventually a live baby was born! But could we use this as the perfect case to prove we were right all along? Not at all! Perhaps a few of the educated men appreciated the fact, but the old mother-in-laws went into a huddle and no doubt concluded to keep to the good old ways! But even with all of this apparent rejection, progress is gradually being made. Recently one

Welcoming the Sisters to their home. New Delhi, India.

mother whose child was discovered to have polio, actually brought the little one to the hospital with a note from the Public Health Nurse! And even though she did refuse to have the child admitted, she is bringing her in for daily treatments. And the night before last, one more granny called our nurses for a delivery in the home! Little by little, TIME, PATIENCE AND PERSEVERANCE are winning out.

Beneath all this rejection of course are many many reasons. Distrust of others is built up through never having experienced brotherly love! Individuals build up resistance to intervention at the possible cost of being exploited. To penetrate all these barriers will naturally take time, but the prognosis is excellent!

In a country where 50% of the children die before the age of 10 years, and most of these before one year; where 70% of the chest X-rays are positive for Tuberculosis; where infectious diseases, particularly dysentery, typhoid and cholera take their toll each year, there is endless opportunity and challenge to build up an army of Public Health Nurses which will bring to their brothers and sisters the blessings of health.

Apostolically the fruits are more than abundant. It not only gives the Sisters a closer and warmer understanding of the people and the culture in which they live, but enables them to meet the people in the ideal environment where more personal contact and less formal atmosphere prevails, than in a hospital.

It is also a fact that a well organized Public Health program CANNOT be successful unless it has a Center, namely a hospital, from which to function, and to which patients who are seriously ill can be referred. But unless more attention is paid to preparing the soil for acceptance of what the hospital has to offer, endless millions will slip by, untouched, untreated, missing thereby the benefits of health and the possibility of knowing and experiencing the blessings of Christian Charity.

Sr. M. Charles, R.N. (Dubuque, Iowa)
now in Kodarma, India, on a public health visit.

NEWS FROM OUR HOUSES

INDIA

Kodarma

We have a house full of patients. One little boy, Rameshwar, has been a great favorite of ours lately. He is about 10 years old but looked as if he were five when they brought him in. He had Typhoid Fever at home and was being treated by a local doctor, in his Village. He was unconscious for 15 days at home, before they brought him to the hospital. They had been giving him barley water the whole time that he was sick, so you can imagine the skin and bones that lay in that bed. It was two weeks before he regained consciousness, here, and now only after a month can he try to walk on two weak spindly legs, supported by his mother who has been with him day and night. You should have seen his mother's face, when he responded to Sister doctor's questions for the first time.

Sr. M. Charles, R. N.
Holy Family Hospital, Kodarma

Buddhist Monastery

Yesterday we went to Ghoom, the famous Buddhist monastery. It is 150 years old and 55 monks live there. They wear red robes and are permitted to marry but their wives and children live in the village. We had hoped to see the famous Devil Dance, but there was no dancing that day. Just as we arrived, two monks on the roof of the temple began to blow long, long horns (of animal horn) — a real feat of breath control, and finally the tune was taken up by two others with metal horns. During the call everyone around rushed into a little prayer room, sat on the floor in front of the idol which was surrounded by lights, incense and offerings of rice and sweets. Each received a white scarf and sat twirling their prayer wheels while carrying on a conversation with his neighbor. We went into the main temple, where there is an image of Buddha about 12 or 15 feet high, surrounded by smaller images, many, many lights, and offerings, including money. On either side were two long couches for the monks. The walls were lined with scrolls. There was incense, too. Outside the temple — of gay yellow, red and blue primarily were other prayer wheels.

Sr. M. Frederic, M. D.,
Mandar, India

Buddhist monks, Ghoom, Darjeeling, blowing the metal trumpets.

June Graduates

Sister M. Austin Jung, (Cincinnati, Ohio) graduate of the University of Cincinnati and the University of Florida, received her M.D. degree from Woman's Medical College, Philadelphia, Pa., in June.

Sister M. Simon, Mehrl, (Dubuque, Iowa), graduate of Briar Cliff College, Sioux City, Iowa, received the degree of Doctor of Dental Surgery from Georgetown University School of Dentistry, Washington, D.C.

Sister M. Paulette Elking, (Dayton, Ohio) graduate of Julienne High School, Dayton, Ohio, received the degree of B.S. in Pharmacy from the St. Louis College of Pharmacy, St. Louis, Mo.

Sister M. Muriel Van Hoene, (Rutherford, New Jersey) graduate of Georgian Court College, Lakewood, New Jersey, received her degree of B.S. in Pharmacy from the St. Louis College of Pharmacy, St. Louis, Mo.

Sister M. Bernardine Premeaux, (Basile, Louisiana) graduate of Mt. Carmel High School, Abbeville, La., and St. Francis Hospital School of Nursing, Trenton, New Jersey, received a diploma from the Nazareth Hospital School of Anesthesiology, Philadelphia, Pa.

Sister M. Genevieve Collin, (Montreal, Canada) graduate of Marguerite Bourgeois High School, Montreal, received her B.S. in Dietetics from the College of St. Teresa, Winona, Minnesota.

New Indian Novitiate

The Feast of St. Benedict, 1958, will always be an important date in the history of the Medical Mission Sisters in India. On that day we broke ground for our new Indian Novitiate. We had not planned the ceremony for that day. It just happened. Mr. Joshi, our contractor, and a Hindu, told us he was going to do puja on the 21st, and start digging the foundation since that day was the Maharastrian New Year's Day and therefore an auspicious one to ask God's protection for the undertaking. Of course, one cannot object to a Hindu asking God's blessing in his own way; yet, we felt that we in our turn, should ask God's Blessing with the ceremony provided by the Church. When we told Father, he offered to come at once to perform the blessing.

The next morning at ten o'clock a little crowd gathered on the top of "our hill". Besides the contractor and his partner, family and relatives, there were the architect, our two supervising engineers (the brothers Ghatpande), Father J. V. Miranda, S. J. and Sisters M. Colette, Vincent, David and Henrietta.

When everybody was ready we had the Blessing. Father put on a surplice and stole and said the prayers while we answered. Afterwards while reciting the asperges the ground was sprinkled with Holy Water.

When the ceremony was over Mr. Joshi did his puja. The contractor seated himself at the right hand of the pujari (Hindu priest). In front of them were little heaps of rice. Mr. Joshi had to drink some water and perform several ablutions. Coconuts, ghee, beetle nuts, pan, a mango branch, and a stone were all used in turn during the puja. The pujari was muttering all the time, prayers and formulas in Sanscrit, so that the gods would not be angry with the earth. When that was over we had the actual "breaking" of the ground. A shovel was forced upon me and with that I had the privilege of turning over the first sod.

We ask you all to pray very especially, that the work which has now begun with God's blessing may come to a good end.

Sister M. Henrietta
Novitiate, Poona, India

Two top graduates of Holy Family Hospital School of Nursing, Rawalpindi, West Pakistan — Colleen and Mathilde. Mathilde will join the staff of Holy Family Hospital, Karachi, W. Pakistan.

AFRICA

Fruitful Sermon

Last Sunday's sermon was all about mangos. Father explained to the Christians that they must train their children to be very honest even in little things: specifically, they mustn't steal the mangos from the mission compound. Father went on to explain how Judas began by stealing small amounts, and from then went on to even greater crimes, finally ending in perdition.

This was all translated to the people by the catechist, as is the local custom of the priest preach-

His Lordship, Bishop Hettinga blessed a new road, built by a Pakistani contractor, with the help of American Friends, for Holy Family Hospital, Rawalpindi, W. Pakistan

ing through an interpreter. (This because of Ashanti custom and formality and not inability to speak the language). The catechist struggled bravely through the long sermon, repeating from memory. But when he came to Judas, he forgot the name. Turning to the priest he asked: "Which saint, Father?"

After Father got him straightened out as to who was Judas, he went on to tell the congregation that they might have as many mangos as they wished, if they would only ask for them, and not steal them. Evidently the sermon was a great success. Afterwards Father received visits from at least twenty of his parishioners. Armed with buckets and basins, and baskets big as wash tubs, they assured Father they were sorry they had stolen his mangos, and could they please have some more.

Sr. M. Ronald
Holy Family Hospital,
Berekum

OLD AND NEW

It is interesting to see the old and new out here. Just the other day I passed a mud hut where a small boy was taking his daily bath while his mother was pounding the "fufu". From the hut I could hear a *radio* blasting the latest news from Accra. The people are so marvelous in their simplicity — very polite and respectful.

Sr. M. Cephas, R. N.
Holy Family Hospital
Berekum, Ghana

YOUR WILL . . .

can help the Medical Mission Sisters bring health and healing to the sick and suffering of mission lands. The following approved form of bequest may be used:

"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $_____for its purposes."

If you have already made your will, it is not necessary to make a new one. It is sufficient that a codicil be added, using the above.

MOTHER TERESA, CHAMPION OF THE POOR

Sister M. Richard

CALCUTTA at mid-day felt hot enough to boil as I stepped from the train onto the crowded streets of one of the world's largest cities. How to describe Calcutta? Sections of it are beautiful with magnificent homes, exquisite flower gardens and spacious parks. There are modern hotels and office buildings architecturally superior to many in the United States but the Calcutta that makes a lasting impression upon the visitors' mind is the Calcutta of the poor. In such a city, the poor are counted in the tens of thousands and their destitution is perhaps the greatest in the world. It is scandalous poverty and revolting as you pass the makeshift shelters and walk around the people who are forced to live and eat and sleep on the streets.

It was twilight when I finished my business and made my way to Lower Circular Road in what is termed "an undesirable section" of the city. Along the way, I met victims of leprosy whose technique for securing alms is really "to make a touch" so that the prospective benefactors are frightened into giving. There were little charcoal fires along the sidewalks and supper was cooking. On the doors of the tiny shops, there was a heavy cord hanging and the tip of it was burning slowly. Later, I found that these cords are for the convenience of smokers, a kind of poor man's cigarette-lighter. It saves him the price of matches. I walked twelve blocks and met several dozen children along the way. None of them were properly clad. I finally reached my destination, the convent of the Missionaries of Charity.

There, at supper (I recall the menu, chappaties and duck eggs fried in mustard oil) Mother Teresa told me the story of the foundation and work of her Society.

Mother Teresa is an Albanian by birth; an Indian citizen by choice. She spent fifteen years as a Loreto nun assigned to a school in the suburbs of Calcutta. Through all these years, she had a desire to go out among the poor, visit them in their homes and help them in any way she could. With ecclestical permission, she left the Sisters of Loreto in 1948. She went to the poor. She learned about their needs first hand. She went to Hindu officials asking them for a place to house the dying she found on the streets. She begged rice for the starving; dispensaries for the sick and school rooms for the children. Mother Teresa received some help; she needed much more. This need became the spring board which led to the foundation of a religious community.

Mother Teresa's idea in establishing the congregation, (and for her Sisters it is a fourth vow) is to have dedicated women go out to work among the poor. She proposes to go to the destitute and care for them in their own surroundings. Her plan of attack is not so much the transformation of the poverty stricken area but rather a giving of assistance to the poor to enable them to rise above their surroundings, teaching them to improve conditions for

themselves. Mother Teresa does not wish to conduct large institutions. Her Sisters are to go out, two by two, each day into the slums. Their work during the past eight years has earned for them the title, apostles to the poor.

During my brief visit with the Missionaries of Charity, I had the opportunity of going with two young Sisters as they made their rounds at the bustee assigned to them. I found that a bustee is a mass of ill ventilated huts crowded together. It is a colony where there is little sanitation, no roads, a few public wells and a few thousand people. The children came to greet us as we approached the area. One Sister set up her school room in the open air. Both teacher and students used the sand at their feet as a blackboard. The other Missionary of Charity announced a cleanup campaign with a prize for the neatest hut in the neighborhood. The coveted prize, a bar of soap, a luxury item for Calcutta's destitute. As I watched these Sisters in action, other teams were carrying on their activities elsewhere. Girls were receiving instruction in needlework; boys were taught how to repair the bamboo huts in which they live. The Sisters told me that the children pass on these practical ideas to parents and they in turn tell friends.

After a four hour stay at the bustee, we walked back to the convent for an hour of prayer in the simple chapel. In true Indian fashion, we knelt on the floor and I watched the intensity with which the Sisters made Cardinal Newman's prayer their own. "Jesus, help me to spread Thy fragrance everywhere I go. Flood my soul with Thy spirit so that my life may be a reflection of Thine."

It would take pages to tell the impressions of an afternoon spent at Nirmala Hriday, the hospice for those in a dying condition. Mother Teresa secured the house which adjoins a Hindu temple, from city officials who recognize the value of her work. They cooperate in this project by permitting city ambulances to bring any homeless person who is desperately ill to Nirmala Hriday. There, the Sisters wash and feed their guests. For many, it is the first attention they have had for weeks. You can imagine the picture of a simple room large enough to hold from 50 to 60 men who lie side by side waiting for death. A second room houses the women. All are grateful for the roof over their heads, the food, the attention, the charity.

Today, those who believe in words are few in number; most men demand the testimony of the love of Christ for the multitude. Mother Teresa and her spiritual daughters give them . . . testimony of the love of Christ for the multitude. Mother Teresa's community is well named . . . Missionaries of Charity.

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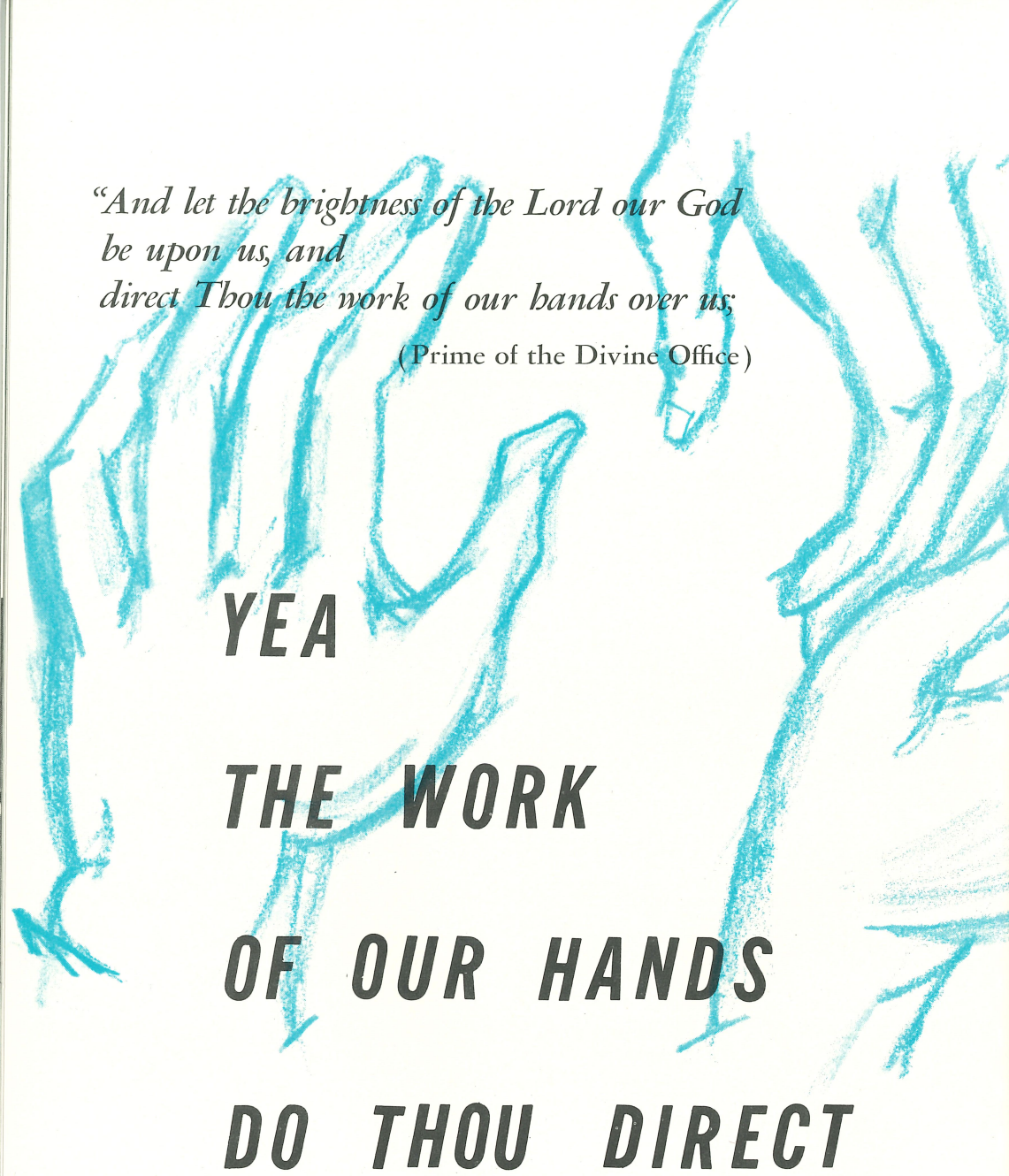

"And let the brightness of the Lord our God
be upon us, and
direct Thou the work of our hands over us;

(Prime of the Divine Office)

YEA THE WORK OF OUR HANDS DO THOU DIRECT

MEDICAL MISSION SISTERS, PHILADELPHIA 11, PA.

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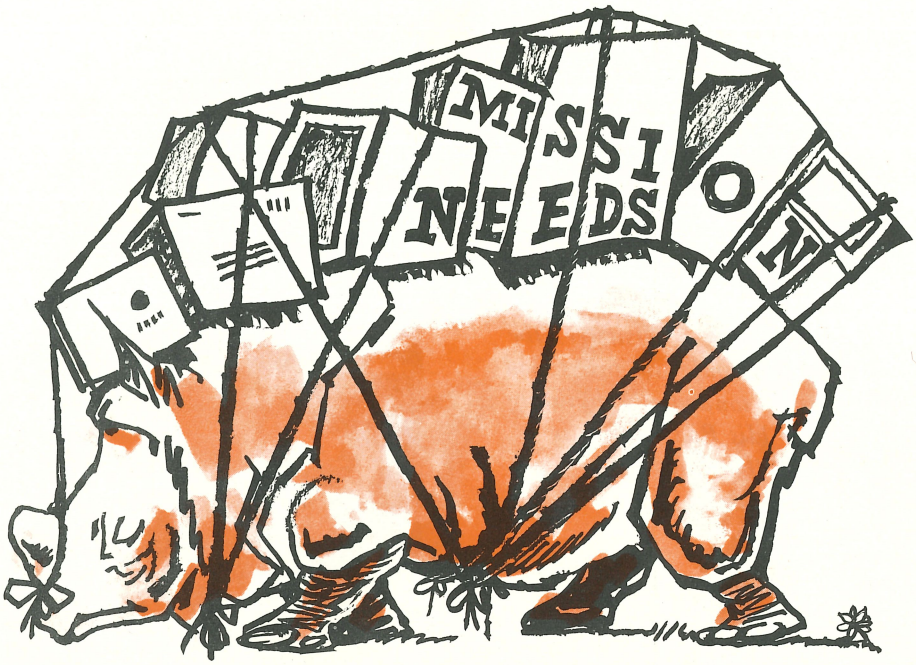
With these words, every Medical Mission Sister begins the day. The service, God asks of her, is something very concrete: a worship she gives Him with her hands, as well as her heart and her head. Whether she peels vegetables or scrubs the pots, compounds a drug, guides a surgeon's scapel — whatever "the work of her hands," she prays God to direct it towards the building up of His Body, which is the Church.



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THANK YOU

Many, many thanks to all who sent packages, donations, and checks for our Garden Party. We appreciate the cooperation and generosity of each one who helped in any way. May God reward you abundantly.

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Dear Sisters:

Here is my gift $.....towards your mission needs in.....

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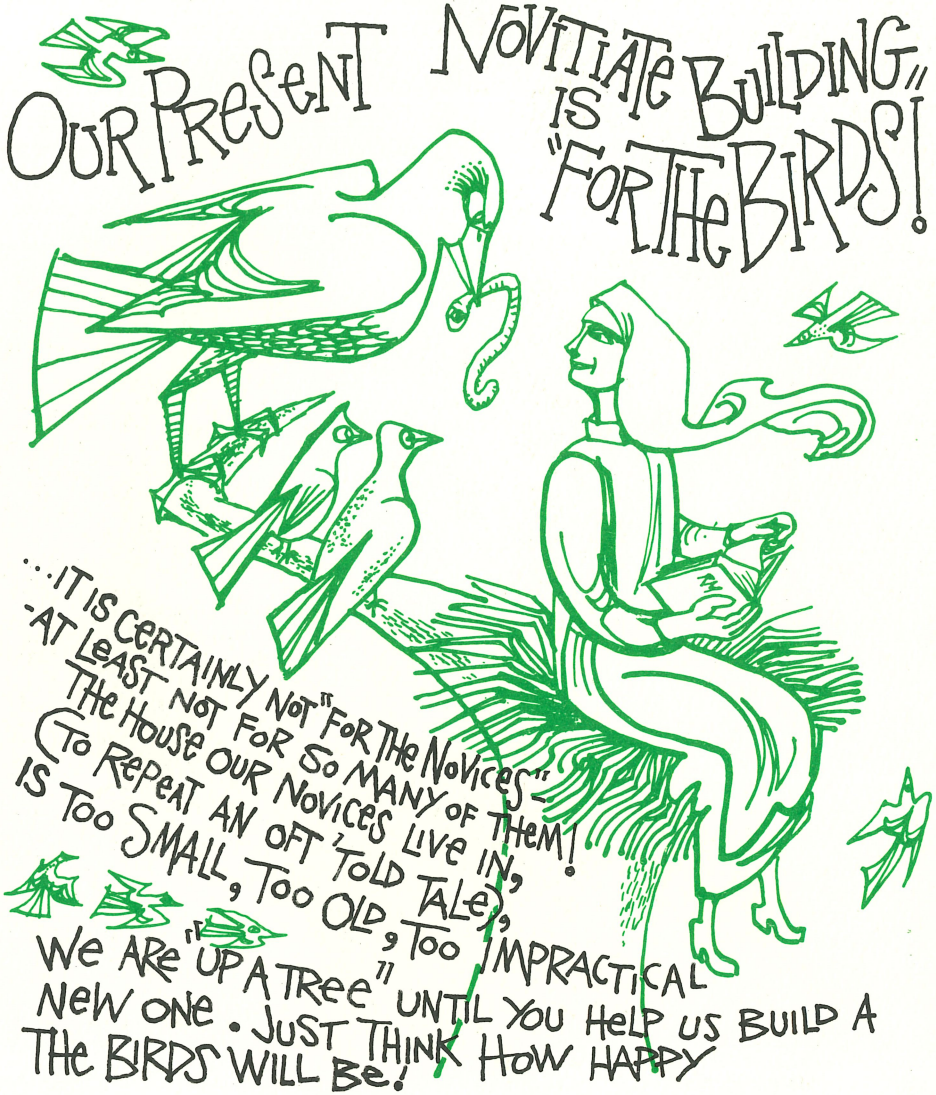
Blessed art Thou among Women, and blessed is the fruit of Thy Womb.
B.V.B.


OUR PRESENT NOVITIATE BUILDING IS "FOR THE BIRDS!
...IT IS CERTAINLY NOT "FOR THE NOVICES" -
-AT LEAST NOT FOR SO MANY OF THEM!
THE HOUSE OUR NOVICES LIVE IN,
(TO REPEAT AN OFT TOLD TALE),
IS TOO SMALL, TOO OLD, TOO IMPRACTICAL
WE ARE "UP A TREE" UNTIL YOU HELP US BUILD A
NEW ONE. JUST THINK HOW HAPPY
THE BIRDS WILL BE!

MEDICAL MISSION SISTERS, PHILADELPHIA 11, PA.

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